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# HOW STRENGTHENING DATA ON FAITH- OWNED HEALTH FACILITIES SUPPORTS HEALTH SYSTEMS

*An analysis of the World Health Organization's 2019 Sub-Saharan Africa Health Facility Dataset by the Christian Health Asset Mapping Consortium*

# EXECUTIVE SUMMARY<sup>1</sup>

The [Christian Health Asset Mapping Consortium \(CHAMC\)](#) seeks to improve understanding of the scope and scale of faith-based health assets in low- and middle-income countries. In line with this, CHAMC undertook an analysis of the 2019 World Health Organization's (WHO) Global Health Facilities Database (HFDB) and compared the results with externally verifiable data sources to identify areas of consistency or gaps in the data and use that to recommend ways to improve upon global data strategies.

The 2019 WHO Sub-Saharan Africa Health Facility Database (SSA-HFDB) integrates 93 data sources to map and describe over 98,000 health facilities in 50 African countries. Analysis of facility ownership in the WHO database identified 3,680 FBO-owned facilities located in 22 of the 50 African countries. There were none, however, in 28 countries, including Uganda, Cameroon, and Liberia, where FBO-owned health facilities are widely known. Some facilities may be missing entirely, while others may not be classified as FBO-owned in their source data. Improving the representation and inclusion of faith-owned health facilities in data could strengthen national and global efforts to plan, support, and enhance the accountability of health systems.

## ABOUT CHAMC

*CHAMC is a voluntary association of organizations that work to address urgent needs for information on and help improve the quality of data about the Christian health asset landscape. The mission of the CHAMC is to increase resources, learning, and partnerships in Christian health services by improving understanding of the nature, scope, and location of those services. Founding Members of the CHAMC include the Africa Christian Health Associations Platform (ACHAP), the Catholic Health Association (CHAUSA), Christian Connections for International Health (CCIH), the International Christian Medical and Dental Association (ICMDA), The Dalton Foundation, and the World Council of Churches (WCC). CCIH serves as the secretariat for the Consortium.*

**Website:** <https://www.ccih.org/christian-health-asset-mapping-consortium/>

**Email:** [mapping.consortium@ccih.org](mailto:mapping.consortium@ccih.org)

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# BACKGROUND

“The COVID-19 pandemic has underscored urgent gaps in our knowledge of where health facilities are located.”<sup>2</sup>

This was an observation made by the World Health Organization on 10 March 2022 at the United Nations Statistical Commission, where it launched the [Geolocated Health Facilities Data \(GHFD\)](#). GHFD was motivated by the urgent need to realize equitable access to essential health services by all and thus achieve universal health coverage. This will be achieved because by serving as a standardized, open, and central repository of health facility information, the GHFD will provide critical insights that ensure every person in every community knows where to go for care and ensure we are better prepared for future health emergencies.<sup>3</sup>

The GHFD will serve as a digitized master health facility list and include “health facility name, location, and type while assigning each a unique code.”<sup>4</sup> At the start, the database will (or is envisaged to) include data for 46 countries representing 40% of the world’s population and to expand to all 194 WHO member states by 2027.

The WHO has provided technical assistance to country-level Ministries of Health (MoH) in data development for over 40 years, including developing health facility master lists in many low- and middle-income countries (LMIC). In 2019, the WHO published a geolocated health facility dataset called the Sub-Saharan Africa Health Facilities Database (SSA-HFDB).<sup>5</sup> This dataset includes records of over 98,000 health facilities in 50 countries; the websites of the respective MoHs were the primary data sources.

The SSA-HFDB is expected to play a critical role in fully implementing the GHFD by providing essential formative lessons. Consequently, and cognisant of the inevitable inclusion of Christian health facilities in the SSA-HFDB and GHFD, the CHAMC reviewed the SSA-HFDB to determine how Christian health networks and providers can best contribute to these efforts.

This policy brief aims to identify areas of commonality or gaps in data and derive recommendations for future data strategies and development.

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<sup>2</sup> [https://www.who.int/news-room/events/detail/2022/03/10/default-calendar/who-global-health-facilities-database-\(ghfd\)-launch-as-part-of-this-year-s-un-statistical-commission-on-10-march-at-09-00-est-15-00-cet](https://www.who.int/news-room/events/detail/2022/03/10/default-calendar/who-global-health-facilities-database-(ghfd)-launch-as-part-of-this-year-s-un-statistical-commission-on-10-march-at-09-00-est-15-00-cet)

<sup>3</sup> *ibid.*

<sup>4</sup> *ibid.*

<sup>5</sup> <https://www.nature.com/articles/s41597-019-0142-2#MOESM1>

# METHODS

The SSA-HSDB data on 98,745 health facilities, especially ownership, was analyzed by country. Ownership/management data include five options:

- Ministry of Health, government or public-owned (MoH)
- Private not-for-profit (PNFP)
- Non-governmental organization (NGO)
- Faith-based organization (FBO)
- Community-based organization (CBO)

The FBO ownership classification was further evaluated by analyzing health facility names and checking to see if the facilities with faith-oriented names were listed as FBO owned (and vice versa).

Further, SSA-HFDB data were triangulated from a sample of 14 Christian health associations (CHAs) in 13 countries in SSA compiled in 2022 by CHAMC.

# FINDINGS AND DISCUSSION

In total, 43 words in the names of the health facilities were found that connote a faith orientation, e.g., Christian, Protestant, sacred, evangelical, Islamic; translated into English and French. There were 1,705 such health facilities in the SSA-HFDB. These were compared with the ownership indicator, for which there were 3,680 FBO-owned facilities in 22 countries. The remaining 28 countries did not report any FBO-owned health facilities. A full breakdown of the 98,745 health facilities according to being “faith-named” and “ownership” is provided in Table 1.

**Table 1: Analysis of ownership and names of health facilities in the SSA-HFDB**

<b>Ownership</b>	<b>Faith Named</b>	<b>Other Named</b>	<b>Total</b>
FBO Owner	752 (44%)	2,928	3,680
NGO Owner	19 (1%)	775	794
PNFP Owner	155 (9%)	961	1116
MOH/Public Owner	702 (41%)	62,005	62,707
Null	77 (5%)	30,371	30,448
<b>Total</b>	<b>1,705 (100%)</b>	<b>97,040</b>	<b>98,745</b>

Less than half (752) of faith-named health facilities are recorded as FBO owned. While FBO-owned health facilities may not be faith-named, it is expected that the opposite is very rare.

The country-by-country comparison showed inconsistency in how data are captured, possibly due to the absence of, or lack of clarity or consensus on, definitions of the different data points. For instance:

- Cameroon: all 219 faith-named facilities are coded as Private-Not-For-Profit (PNFP).
- Uganda: there are only two values for ownership: MoH and PNFP, all 119 faith-named facilities are coded as PNFP, and no facilities are indicated to be FBO owned.
- Democratic Republic of Congo: 250 faith-named facilities are coded as MoH.
- Nigeria: 99% of the 20,807 health facility records do not contain ownership information, representing over 20% of the SSA-HFDB.

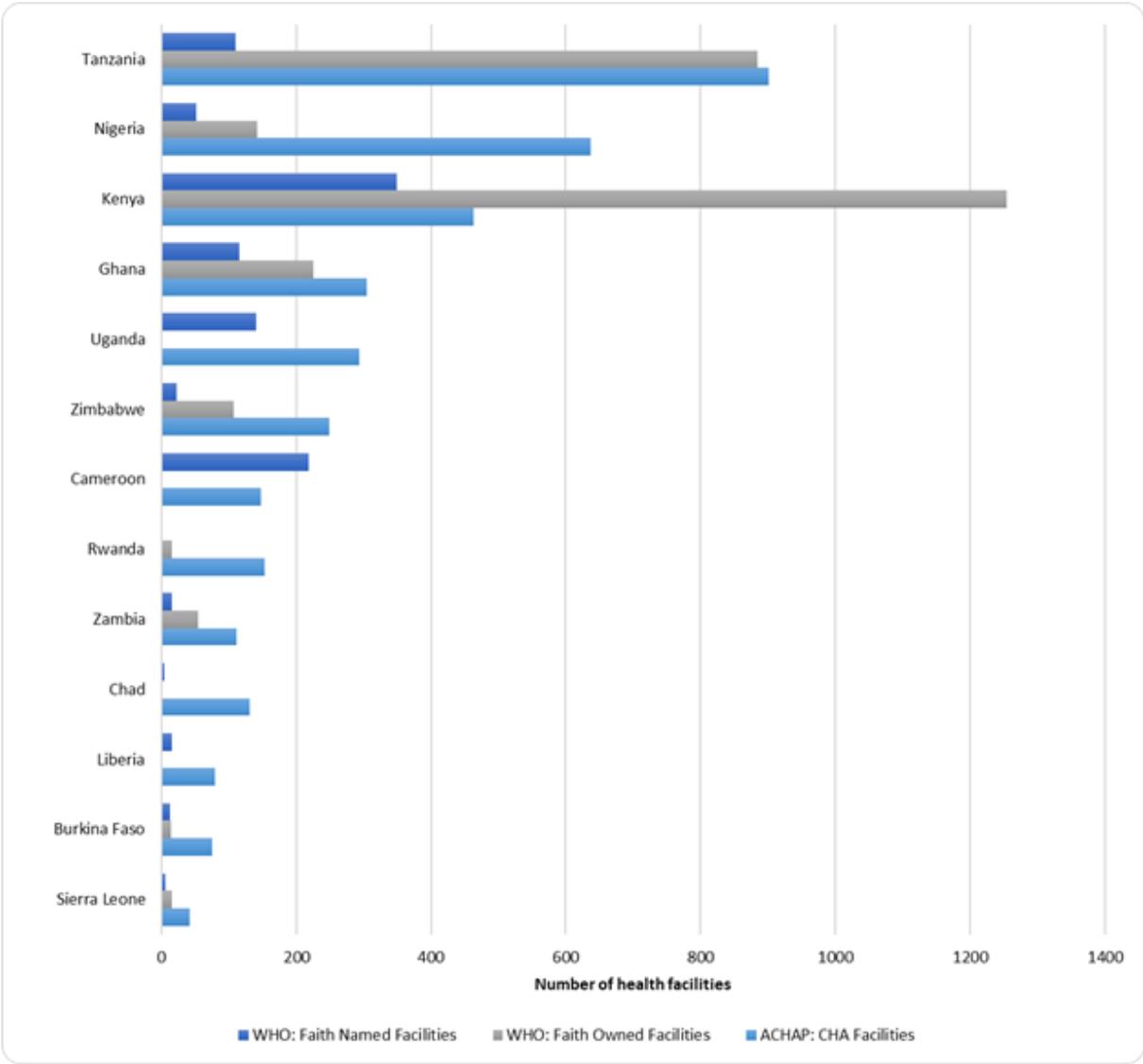
Moreover, in several of the 28 countries where no FBO-owned facilities are recorded in the SSA-HFDB, there are FBO-owned health facilities under CHAs; examples include Uganda, Cameroon, and Liberia.

Triangulation of the SSA-HFDB with our data from CHAs showed further gaps in the SSA-HFDB. Data from 14 CHAs in 13 countries reveal 3,717 Christian health facilities (hospitals and clinics). Figure 1 compares these FBO-owned health facilities with what was obtained in the SSA-HFDB for the 13 countries.

The CHAs in the 13 countries reported more FBO-owned health facilities than the entire SSA-HFDB. The CHAs reported more FBO-owned health facilities than the SSA-HFDB in every country, both by their names and by their ownership, except for Kenya and Cameroon, where our datasets were incomplete. For Kenya, the previous data had excluded the Catholic health network, while for Cameroon only included the Baptist health network.

One additional source of error is suspected: how duplicates were managed. The WHO indicates that the presence of duplicates was familiar across all databases, and where identified, they were discarded. Without unique identifiers and an independent data source to triangulate, the WHO might have used inadequate means to decide which duplicates to delete, invariably compromising the final dataset.

**Figure 1: Comparison of FBO-owned facilities in CHAMC and SSA-HFDB databases**



# CONCLUSION

The 2019 WHO SSA-HFDB represents a significant effort to bring master health facility lists for 50 countries in one data set, most likely a pioneer WHO region to make such a contribution towards the GHFD agenda. Understandably, this effort has brought to light critical areas for improvement to ensure data accuracy and compatibility and to make it worthwhile for the GHFD.

FBOs invest significant resources in health facilities, recognition of which is vital to sustaining their contributions to the health system. MoHs, FBOs, and WHO share responsibility for ensuring the integrity of the data emerging from the national level up to the global platform. A more precise understanding of the faith-based health landscape is necessary to ensure that health system leaders can access the best available information to support health system planning, strengthening, and accountability.

# RECOMMENDATIONS

Acknowledging that the SSA-HFDB may contribute to the GHFD, we make the following recommendations to WHO, MoHs, and FBOs:

1. WHO should improve the health facility master lists by assigning a unique identification number to each facility to eliminate duplicates, promote data aggregation and facilitate data updating;
2. WHO should collaborate with MoHs and FBOs, and other partners to agree upon standard indicator definitions, including on ownership, to help make the GHFD more credible and comparable;
3. FBOs should be more proactive in maintaining quality, up-to-date, and accessible datasets, including through MoHs, that can inform and enrich data strategies;
4. WHO, as much as possible, should ensure inclusivity by consulting data from other health actors, especially FBOs, are significantly invested in health service delivery.